

HEALTH CLAIM FORM

The Health Claim form must be filled by the Owner / Proposer / legally entitled person under the policy

CHECKLIST FOR SUBMISSION OF HEALTH CLAIM

Policy number(s) _____

Name of Owner / Proposer _____ Date DD/MM/YYYY

Mobile No. _____ Alternate Mobile No. _____

MANDATORY DOCUMENTS REQUIRED FOR MAKING A CLAIM	SUBMITTED	
1. Duly filled and signed health claim form	Yes	No
2. Owner / Proposer address proof*	Yes	No
3. Owner / Proposer photo identity proof*	Yes	No
4. Recent photograph of the Owner / Proposer	Yes	No
5. Pan card / Form 97 (as applicable and defined in Income-tax Rules, 2026) of the Owner / Proposer	Yes	No
6. Payout mandate form with bank account details of the Owner / Proposer	Yes	No
7. Copy of cancelled cheque / bank statement / bank passbook of the Owner / Proposer**	Yes	No

*Any one of the officially valid documents such as Aadhar Card, Passport, Driver's License, Voters ID

**As per the regulatory requirement, all payouts under an insurance policy are required to be processed electronically in the bank account of the policyholder/nominee/assignee/trustee as applicable.

MANDATORY DOCUMENTS REQUIRED FOR FIXED BENEFIT HOSPITALIZATION CLAIMS APPLICABLE FOR ICICI PRU HOSPITAL CARE/ ICICI PRU HOSPITAL CARE II	SUBMITTED	
1. All hospitalization records of the Life Assured such as copy of:		
• Discharge summary	Yes	No
• Final Bill	Yes	No

MANDATORY DOCUMENTS REQUIRED FOR INDEMNITY HOSPITALIZATION CLAIM APPLICABLE FOR ICICI PRU MEDIATESSURE / ICICI PRU HEALTH SAVER	SUBMITTED	
1. All medical records of the Life Assured such as:		
• Original Discharge summary	Yes	No
• Original hospital final bill with payment receipt	Yes	No
• Original pharmacy/investigation report bills with payment receipt	Yes	No
• Diagnostic test reports such as blood reports, ECG, Xray, MRI, CT scan, pathology reports etc.	Yes	No

MANDATORY DOCUMENTS REQUIRED FOR CRITICAL ILLNESS CLAIM / TERMINAL ILLNESS CLAIM / MAJOR SURGICAL ASSISTANCE RIDER / ACCIDENTAL DISABILITY RIDER (APPLICABLE FOR ICICI PRU CRISIS COVER / RIDER CLAIM / HEART AND CANCER PROTECT / ICICI PRU WISH)	SUBMITTED	
1. Medical documents confirming diagnosis		
• A precise diagnosis of the treatment for which a claim is made	Yes	No
• All hospitalization records of the Life Assured such as: First and all consultation / Follow up paper, Past medical records, Admission form, Indoor case papers (ICPs), Discharge summary, Diagnostic test reports confirming diagnosis	Yes	No
• Treating Doctor Certificate - Confirming the diagnosis	Yes	No
• For disability claim: First Information Report (FIR) from the police authority/ general diary entry, Medico-legal certificate (applicable for disability claim)	Yes	No
2. Duly filled in employer certificate (only if Life Assured is a salaried individual)	Yes	No

INSTRUCTIONS FOR FILLING THE FORM

A. IMPORTANT INFORMATION (Please read before filling the form)

1. Incomplete claim form and submission of partial documents is the main reason for delay in claim settlements. We therefore request you to update all the details as required in the Claim Form and also submit all the mandatory documents.
2. We recommend that this form to be filled and signed by the Owner / Proposer himself/ herself, as the information / details in the claim form required are critical for claim processing.
3. Please update and provide correct address, valid / active phone number, email ID of the Owner / Proposer as claim related communications/ correspondence will be done by the Company through these contact details.
4. If the Life Assured holds more than one policy and Owner / Proposer is same under all policies; one Claim Form is sufficient for claim registration. All the policy numbers should be mentioned in the same claim form.
5. 'No Objection Certificate'/ 'Loan Closure Statement' from the Financial Institution is also a mandatory document required for the purpose of calculating the claim benefit in addition to the documents mentioned on page 1.
6. Please read the declarations carefully before signing. The Owner/Proposer should sign the Claim Form in the same manner as he/she would normally sign their cheque. It is the Owner/Proposer's responsibility to ensure that the signatures on all documents are accurate and consistent.
7. Please refer to the policy document or visit Company website for complete list of documents required to be submitted and submit all mandatory documents at the first instance as these are critical documents for claim assessment. This will facilitate faster claim processing.
8. Turn around time for claim processing and settlement will start only after receipt of all mandatory documents.
9. The Company reserves the right to call for additional documents / requirements on case-to-case basis.
10. No fee or commission should be paid to anyone for claim registration / processing.

B. KYC (KNOW YOUR CUSTOMER) DOCUMENTS (OF THE OWNER / PROPOSER):

Below mentioned documents are considered as KYC documents.

- Address Proof (Aadhar Card, Passport, Driver's License, Voters ID)
- Identity Proof (Aadhar Card, Passport, Driver's License, Voters ID)
- Recent Photo
- Pan Card / Form 97 (as applicable and defined in Income-tax Rules, 2026)

C. OWNER / PROPOSER NEFT MANDATE / BANK ACCOUNT DETAILS

- As per the regulatory requirement, all payouts under an insurance policy are required to be processed electronically in the bank account of the Policyholder / Nominee / Assignee/Trustee as applicable.
- A cancelled personalised cheque with the account number and IFSC code should be submitted along with the Payout mandate.
- If the cheque is not personalised, the latest bank statement or copy of passbook (where account number and IFSC code are mentioned) should be submitted along with the Payout mandate.
- If the account in which the claim proceeds are requested is a joint account held with person/ individual other than the Life Assured, then declaration from Owner/Proposer authorising the Company to initiate payout in a joint account is required.
- This mandate, upon processing, will override any of the previously tagged NEFT mandates for all policies, held by the Life Assured/ Policyholder with ICICI Prudential Life Insurance Co. Ltd.
- In case of NEFT failure or any further requirements pending on the mandate, payout will be kept on hold and request to submit a fresh payout mandate will be communicated.
- Claim proceeds to NRE account (full or proportionate) will be subject to ratio of premium(s) paid through NRE Account. Please submit a Bank Statement or Bank Confirmation letter as evidence for premium(s) paid through NRE account. In case of proportionate payout, please provide two payout mandates i.e. for NRE account and non-NRE account.

CONTACT US:



Call 24X7 Claim helpline:

1800 2660 (For calls within India)

+91 8069385555 (For calls outside India)



Email us:

claimsupport@icicprulife.com



Chat on WhatsApp:

Type 'Claim' and send
to 9920667766



Visit our branch:

To Locate

www.icicprulife.com → contact us

The Health Claim form must be filled by the owner / proposer / legally entitled person under the policy

SECTION A

8 digit policy number(s): _____
(Please mention all policy numbers with ICICI Prudential Life Insurance Co. Ltd.)

Phone No: Email ID:

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:

b) Name of treating doctor

c) Address of hospital

d) Contact No:

e) Room Category ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐ AC ☐ NON AC ☐ ICU ☐ NON ICU

f) Date of diagnosis g) Diagnosis

h) Date of Admission: i) Time: j) Date of Discharge: k) Time:

l) If Injury give cause: ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

i) If Medico legal: ☐ Yes ☐ No ii) Reported to police ☐ Yes ☐ No iii) MLC Report and Police FIR attached: ☐ Yes ☐ No

m) System of Medicine: ☐ Allopathy ☐ Ayurveda ☐ Homeopathy ☐ Unani others (please specify) _____

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: ₹ ii. Hospitalization Expenses: ₹

iii. Post-hospitalization Expenses: ₹ iv. Health-Check up Cost: ₹

v. Ambulance Charges: ₹ vi. Others (code): ₹

Total: ₹

vii. Pre-hospitalization period: Days viii. Post-hospitalization period: Days

b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed: (Please specify number of days claimed against each benefit)

i. Daily Hospitalization Cash Benefit: ₹ ii. Surgical Cash Benefit: ₹

iii. ICU Hospitalization benefit: ₹ iv. Convalescence benefit: ₹

v. Non Surgical benefit: ₹ vi. Recuperating benefit: ₹

vii. Prolonged stay benefit: ₹ viii. Others (code): ₹

Total: ₹

d) Critical illness benefit claimed: (₹ Amount) _____ and Name of critical illness claim for which benefit is claimed _____

DETAILS OF BILLS ENCLOSED:

SI No.	Bill No.	Date	Issued by	Towards	Amount (₹)
1				Hospital Main Bill	
2				Pre-hospitalization Bills: Nos	
3				Post-hospitalization Bills: Nos	
4				Pharmacy Bills	
5					
6					
7					
				Total claim amount	

HEALTH/ HABIT DETAILS OF LIFE ASSURED:

Nature of Illness / Habit (Please select ū/û)	Duration (since when)	If Yes, Treatment/Quantity Details
☐ Hypertension ☐ Diabetes		
☐ Heart disease ☐ Liver disease ☐ Kidney disease ☐ Cancer		
☐ Any other ailments / disorder/ surgery/ hospitalisation in last 5 Yrs		
☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs		

LAST EMPLOYER DETAILS OF OWNER/PROPOSER (If applicable) _____

Name of the Company _____ Name of contact person _____ Contact No. _____

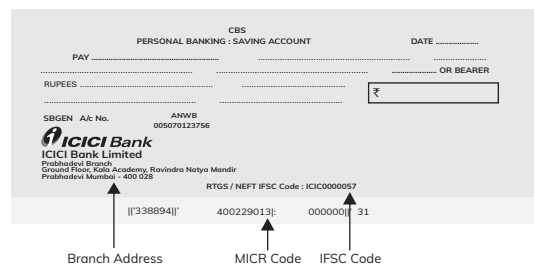
Address: _____

E-mail ID: _____ Last working date: _____ Designation: _____

Dates		Reasons as per Medical Certificate / Leave Application	Employer Insurance Availed Yes / No
From	To		

Name of the Company / TPA	Policy No. Date	Risk Commencement	Sum Assured	Claim Raised Yes/No	Illness/ Disease	Date of Illness

Place: Date:



Please select Payout Options at claims stage (if any change required)			
Benefit Option opted at issuance	Applicable for Products: ICICI Pru IProtect Smart		
(a) Income Option	☐ As opted at policy inception	☐ Advance 1st year's income as lump sum and remaining in monthly instalments	☐ Lump sum (*Present value of future payouts)
(b) Increasing Income Option	☐ As opted at policy inception	☐ Advance 1st year's income as lump sum and remaining in monthly instalments	☐ Lump sum (*Present value of future payouts)
(c) Lump sum and Income Option	☐ As opted at policy inception	Not Applicable	☐ Lump sum (*Present value of future payouts)
(d) Lump sum Option	☐ As opted at policy inception	Not Applicable	Not Applicable
Note	1) If the instalment payment is less than the minimum instalment amount, the claim proceeds shall be paid in lump sum only. 2) Change in benefit option at claims stage is not applicable if benefit option "Lump sum" is chosen at the start of the policy		

SECTION C

TO BE FILLED BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability

DETAILS OF HOSPITAL

a) Name of the Hospital:

b) Hospital ID: c) Type of Hospital: ☐ Network ☐ Non Network

d) Name of the treating doctor: e) Qualification:

f) Registration No. with State Code: Phone No:

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: b) IP Registration Number:

c) Gender: ☐ Male ☐ Female d) Age: Years Months e) Date of birth:

f) Date of Admission: g) Time: h) Date of Discharge: i) Time:

j) Type of Admission: ☐ Emergency ☐ Planned ☐ Day care ☐ Maternity

k) If Maternity: i) Date of Delivery: ii. Gravida Status:

l) Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD10 Codes	Description	b)	ICD10 Codes	Description
i. Primary Diagnosis:			i. Procedure1:		
ii. Additional Diagnosis:			ii. Procedure2:		
iii. Co-morbidities:			iii. Procedure3:		
iv. Pre-existing illness:			iv. Details of Procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Claim:

f) Hospitalization due to Injury: ☐ Yes ☐ No

i. If Yes, give cause: ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports)

iii. If Medico legal: ☐ Yes ☐ No • Reported to Police : ☐ Yes ☐ No v. FIR no.

vi. If not reported to police give reason:

DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of the Hospital:

City: State: Pin Code:

b) Phone No: c) Registration No. with State Code:

d) Hospital PAN: e) Number of Inpatient beds:

f) Facilities available in the hospital: i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No

iii. Others:

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: Place:

Signature and Seal of the Hospital Authority:

SECTION D

DECLARATION AND AUTHORISATION

- I hereby declare that all the details filled/furnished above are true and correct to the best of my knowledge and belief
- I hereby warrant the truth and correctness of the foregoing particulars in every respect, and I agree that if I have made or shall make any false or untrue statement, suppress or conceal any material fact, my right to claim the benefits under the policy shall be forfeited.
- I understand and agree that the submission of this form is not to be considered as acceptance of the claim.
- I understand that any payout under the policy shall be strictly made in accordance with the policy terms and conditions.
- Any payment shall be subject to realisation of the last renewal premium payment.
- I voluntarily provide my consent to use my Aadhaar to conduct identity check towards KYC compliance by ICICI Prudential Life Insurance Co. Ltd.
- Notwithstanding any consent provided previously or any provisions of any law, usage, custom or convention for the time being in force prohibiting any physician or Hospital from divulging any knowledge or information acquired by him/them in attending upon or examining the Life Assured on the ground of secrecy, I hereby authorise all the medical establishments (including medical labs), government institutions (such as police, revenue departments, etc.) to share any medical information including the treatment related to HIV/AIDS and other conditions related to the Life Assured to ICICI Prudential Life Insurance Co. Ltd. or in the court of law, as required. This authorization applies to information obtained both before or after the issuance of policy.
- A photocopy of this declaration shall be considered as valid and effective for the purpose of obtaining all records including medical treatment / death of the Life Assured.
- I authorise and provide my consent to ICICI Prudential Life Insurance Co. Ltd. to share and obtain information/ documents (including photocopies) on behalf of me with any Reinsurer, Insurance Association, Medical Authorities, Other Insurers, Statutory Authorities, Employer, Business Associates, Court, Governmental Body, Regulator, etc using an investigation agency or vide any other mode.
- I hereby provide my consent and authorize ICICI Prudential Life Insurance Co. Ltd. to use my PAN details and other information provided by me/us in this claim form to register/update/download/verify my/our KYC documents on/from the CERSAI* CKYC portal for processing this claim, any future applications, or any other requests. I/We understand that only the acceptable officially valid documents would be relied upon for processing any requests/applications. (*Central Registry of Securitization and Asset Reconstruction and security Interest of India)

Signature/Thumb impression of the Owner/Proposer		Name and signature of the witness	
		Mobile number of the witness	
Mobile number of Owner/Proposer		Witness's relationship with Owner/Proposer	
Date		Place	

Declaration to be made by a third person in case form is filled/ signed in vernacular language

The Owner/Proposer has affixed his/ her thumb impression/ has signed in vernacular/ has not filled the application. I hereby declare that the content of this form has been explained to the Owner/Proposer in _____ language and he/she has signed/ affixed his/ her thumb impression in my presence after fully understand the same. I further declare that I have truthfully recorded the details provided to me.

Name of the Declarant: _____

Address: _____

Place: _____

Date: DD/MM/YYYY

Important Note: In case of any demand or favour asked by anyone including a company representative towards claim processing or settlement, the same should not be entertained and must be reported to the company immediately on the company's Email ID: claimsupport@iciciprulife.com.

Signature of Declarant

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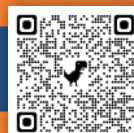
BEWARE OF SPURIOUS / FRAUD PHONE CALLS

IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint.



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AUTHORIZATION

To,

The Claims department,

ICICI Prudential Life Insurance Company Limited,

Subject: Authorisation letter from Owner/Proposer for conducting checks and obtaining documents

Policy Number(s):_____

I, Mr./Ms._____(name), _____(relation) of
Mr./Ms._____(name of the Life Assured) hereby give my consent to "ICICI
Prudential Life Insurance Company Ltd., and/or its representative to obtain records(including photocopies)/information
pertaining to the Employment records, medical treatment records from any Hospital/Clinic/Doctor or any other records
pertaining to treatment/occupation of life assured, I grant my unequivocal consent for collection and review of such
records by ICICI Prudential Life Insurance Company Ltd. This authorisation and consent shall supersede and override any
prior consents provided for the purpose of obtaining the relevant records.

Yours faithfully,

Owner/Proposer Signature

Witness Signature

Name of life assured _____

Name of the Witness _____

Date:_____

Address of Witness: _____

Date:_____

ACKNOWLEDGEMENT RECEIPT FOR SUBMISSION OF HEALTH CLAIM

Policy number(s) _____

Name of the Owner/Proposer _____

Name of Owner/Proposer _____

Branch name _____ Branch code _____ Date DD/MM/YYYY _____

Employee name _____ Employee code _____

STAMP and TIME

Note:

- The acknowledgment slip should not be construed as acceptance of claim.
- Turn around time for claim processing will start only after receipt of all mandatory documents.
- Company reserves the right to call for further documents incase the details or information provided in relation to the claim is found to be incorrect / incomplete.
- Please refer to the policy document or visit Company website for complete list of mandatory documents required to be submitted along with the claim form.
- Please submit the claim forms in Company prescribed formats, as available on the Company Website
- Claim is payable subject to receipt of premiums due under the policy from the insured and fulfilment of all terms and conditions of the policy.
- Any payout under the policy shall be strictly made in accordance with the terms and conditions of the policy.
- Claim proceeds can be credited in NRE accounts in proportion to the premiums paid through NRE account subject to valid proofs being submitted in support of premium payment.

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